RYAN WHITE TITLE I PRESCRIPTION DRUGS FORMULARY

This is a comprehensive list of medications that may be required by individuals with HIV Spectrum Disease. Some medications are listed more than once as they may be indicated for different conditions. The formulary was organized in this manner to encourage practitioners to use medications appropriately. **All items will be reimbursed in their generic equivalent. Reimbursement for name brand items will only be permitted in the event that a generic equivalent is not available on the market.** There may be special situations where medications are needed that are not on this list (i.e., HIV-related heart disease or HIV-related kidney failure) and a mechanism should be set up to deal with such extenuating circumstances. Medications available through the federal AIDS Drug Assistance Program **(ADAP)** via the Miami-Dade County Health Department are identified with a symbol (♦). These drugs are available to clients fulfilling the ADAP eligibility requirements.

I. PROPHYLACTIC MEDICATIONS

	Generic Name	Trade Name (for reference only)
PCP	Pentamidine for inhalation	Pentam, Nebupent
MAC	Clarithromycin♦	Biaxin
	Azithromycin♦	Zithromax
	Rifabutin♦	Mycobutin
	Pneumococcal Vaccine ♦	Pneumovax
Fungal	Ketoconazole	Nizoral
	Amphotericin B (Oral)	Fungizone
	Fluconazole♦	Diflucan
	Terconazole♦	Terazol
	Miconazole Topical♦	Miconazole Nitrate 2%
	Itraconazole▪	Sporanox 100mg (Capsules)
Nutritional	Multivitamins with minerals	Prenatal Vitamins
	Potassium (Oral)	
	Antioxidant formula	
	Boost Liquid*	
	Progain Powder◊	
	Berocca Plus	
	Pyridoxine	Vitamin B6
	Resource Just for Kids*	
	Not Available∫	IgG Pure◊
Hepatitis	Hepatitis A Vaccine ♦	Havrix Adult
	Hepatitis B Vaccine ♦	Engerix B Adult

- **NOTE: In order for a patient to obtain this medication through the Title I program, one of the two conditions (histoplasmosis or aspergillosis) must have been identified and documented in the client's chart by his/her physician. In addition, the Ryan White Sporanox Letter of Medical Necessity is required. Title I funds may only be used to cover one of the two conditions.**

* **NOTE: The Ryan White Nutritional Supplements Letter of Medical Necessity is required. Title I funds may only be used to reimburse for nutritional supplements for the treatment of indications experienced by HIV+ children 18 years and under (for Boost Liquid) and HIV+ children 1-10 years of age (for Resource Just for Kids). These nutritional supplements are only available in liquid form.**

◊ **NOTE: These nutritional supplements are available in powder form only and require a referral from both a physician and a nutritionist.**

ĵ **NOTE: There is no generic equivalent for this new brand name product.**

II. ANTIRETROVIRALS

Title I funds may be used to reimburse for antiretrovirals (on a month-to-month basis) only when these medications are unavailable through ADAP.

	Generic Name	Trade Name (for reference only)
Nucleoside Reverse Transcriptase Inhibitors	Zidovudine	Retrovir (AZT)♦
	Didanosine (ddI)♦	Videx
	Zalcitabine (ddC)♦	Hivid
	Stavudine (d4T) ♦	Zerit
	Lamivudine (3TC) ♦	Epivir
	Zidovudine/lamivudine ♦	Combivir
	Abacavir (1592) ♦	Ziagen
	Hydroxyurea (HV) ♦	Hydrea
	Abacavir Sulfate/ Lamivudine/Zidovudine (Tablets) 150 mg/300mg♦	Trizivir♦
	Didanosine (ddI) 400 mg♦	Videx EC (Capsules)♦
	Tenofovir (300 mg tablet)♦	Viread♦
	Emtricitabine♦	Emtriva♦
Protease Inhibitors*	Indinavir♦	Crixivan
	Ritonavir♦	Norvir
	Saquinavir♦	Invirase, Fortovase
	Nelfinavir♦	Viracept
	Amprenavir ♦	Agenerase
	Lopinavir/Ritonavir (Capsules & Oral Solution)♦	Kaletra ♦
	Atazanavir♦	Reyataz♦

	Generic Name	Trade Name (for reference only)
	Fosamprenavir Calcium♦	Lexiva
Non-Nucleoside Reverse Transcriptase Inhibitors	Delavirdine♦	Rescriptor
	Nevirapine♦	Viramune
	Efavirenz♦	Sustiva
	Efavirenz♦	Sustiva 600mg

* **NOTE: Effective January 1, 1998 Title I funds may be used to reimburse for Protease Inhibitors and Non-Nucleocide Reverse Transcriptase Inhibitors (on a month-to-month basis) only when these medications are unavailable through ADAP.**

III. TREATMENT OF INFECTIONS/CONDITIONS

Candida	Lidocaine (viscous)	Xylocaine
	Nystatin suspension	Mycostatin/Nilstat
	Clotrimazole (troches & cream)	Mycelex
	Ketoconazole	Nizoral
	Itraconazole ♦	Sporanox (Oral)
Crypotosparidium L Belli	Paromomycin	Humatin
	Metronidazole	Flagyl
CMV	Ganciclovir (for IV infusion)	
	Ganciclovir (oral)	Cytovene
	Foscarnet (for IV infusion)	
	Valganciclovir	Valcyte
	Valacyclovir 500mg/1000mg (tablets)▪	Valtrex

▪ **NOTE: In order for a patient to obtain this medication through the Title I program, one of the following conditions must have been identified and documented in the patient's chart by his/her physician: (1) patient has acute Herpes Zoster, and requires Valacyclovir 1000mg three (3) times daily; or, (2) patient requires Valacyclovir daily suppressive therapy for recurrent Herpes Simplex episodes occurring while receiving standard doses of daily suppressive Acyclovir therapy. To qualify for daily suppressive Valacyclovir therapy, the patient must have had <u>more than one</u> Herpes recurrence while receiving daily Acyclovir suppressive therapy. This must be documented by attaching a photocopy of a recent Acyclovir prescription to the Letter of Medical Necessity submitted with the <u>first</u> prescription for Valacyclovir tablets. This is not required on subsequent refills. Title I funds may <u>only</u> be used to pay for this medication if one the patient is suffering from one of the two conditions specified above.**

	Generic Name	Trade Name (for reference only)
Dermatitis (seborrheic and other)	Hydrocortisone Topical (cream & ointment)	Hytone
	Triamcinolone (cream & ointment)	Kenalog
	Neomycin/polymixin/zin	Bacitracin
	Aquaphor (generic)	
	Betamethason	Valisone
	Capsaicin	Zostrix
	Clobetasol ointment	Temovate
	Fluocinonide	Lidex
	Flurouracil	Effudex
	Permethrin	Elimite
	Podofilox	Condylox
	Sarna lotion	
	Imiquimod 5%	Aldara Cream
	Erythromycin Topical Solution	A/T/S Solution
	Benzoyl Peroxide Topical (5%-10% ointment)	Benzamycin
	Fluocinolone (gel & ointment)	
	Doxepin	Sinequan
Herpes	Silver Sulfadiazine	Silvadene
	Acyclovir♦	Zovirax
Influenza A/B	Oseltamivir	Tamiflu
Mycobacterium Avium (MAC)	Clarithromycin♦	Biaxin
	Ethambutol ♦	Myambutol
	Azithromycin ♦	Zithromax
	Rifabutin♦	Mycobutin
	Pneumococcal Vaccine ♦	Pneumovax
Tuberculosis	Rifampin	Rifadin, Rimactane
	Isoniazid (INH)	Laniazid, Nydrazid
	Pyrazinamide	PZA
	Ethambutol♦	Myambutol
	Dapsone (DDS)♦	Avlosulfon

	Generic Name	Trade Name (for reference only)
PCP	Trimethoprim/ Sulfamethoxazole ♦	Septra/Bactrim
	Clindamycin	Cleocin
	Primaquine	
	Atovaquone ♦	Mepron
	Trimetrexate	
	Prednisone	
Syphilis	Penicillin (VK, benzathine, aqueous)	
	Amoxicillin	
	Amoxicillin / Clavulinic acid	Augmentin
	Probenecid	Benemid
Thrombocytopenia	Danazol	
	Prednisone	
Toxoplasmosis	Sulfadiazine	
	Pyrimethamine♦	Daraprim
	Clindamycin	Cleocin
	Leucovorin* ♦	Folinic acid*

* **NOTE: Title I funds may only be used to reimburse for this medication for the treatment of Toxoplasmosis, and must be written as such on the prescription.**

Diarrhea	Erythromycin	
	Ofloxacin	Floxin
	Diphenoxylate♦	Lomotil
	Loperamide	Imodium
	Tincture of opium	
Wasting/ Weight loss	Cyproheptadine	Periactin
	Dronabinol **(1 b.i.d dosage, 2.5 mg)***	Marinol*
	Megestrol* ♦	Megace Suspension*
	Pancrelipase*	Ultrase*
	Oxandrolone ** ♦	Oxandrin **
Anabolic Agents	Testosterone (Injection)▪ ♦	Testosterone Enanthate▪ or Cypionate
	Testosterone Gel***	Androgel 1%
	Generic Name	**Trade Name**

		(for reference only)
	Nandrolone** ♦	Deca Durabolin **
	Oxymetholone **	Anadrol-50 **
Neuropathy/ Anti-Convulsants	Phenytoin (Dilantin)	Dilantin
	Carbamazepine (Tegretol)	Tegretol
	Amitriptyline ♦	Elavil
	Imipramine	Tofranil
	Desipramine	Norpramin
	Valproate	Depakote
	Gabapentin ♦	Neurontin
	Lamotrigine ♦	Lamictal
	Nortriptyline	Pamelor
Lymphoma	Procarbazine	Matulane

* **NOTE: The Ryan White Appetite Stimulant Letter of Medical Necessity is required, and the need for this medication must be reassessed monthly. Title I funds may only be used to cover one (1) b.i.d. dosage, 2.5 m.g. of Dronabinol (Marinol).**

▪ **NOTE: To qualify for Title I coverage, the patient's testosterone level must be below a normal reading. Prescribing physicians must include the patient's most recent testosterone level on the prescription for this medication. If this information is not provided on the prescription, Title I will not cover the cost of this medication.**

** **In order for a patient to obtain this medication through the Title I program, one of the following conditions must have been identified and documented in the client's chart by his/her physician:**

1. **The patient is experiencing involuntary weight loss of 3% in 1 month, 5% in 6 months, or 10% in 12 months.**

or

2. **If the patient's baseline weight is not available, then the patient will qualify for Title I assistance if his/her Body Mass Index (BMI) is less than 80% of a normal reading.**

*** **To qualify for Title I coverage, the patient must experience a low serum testosterone level as defined by the current medical guidelines of the Florida Department of Health and Human Services (a testosterone level below normal as measured by the reference lab.) Prescribing physicians must include the patient's most recent testosterone level on the Letter of Medical Necessity for Testosterone Gel (Androgel ® 1%). If this information is not provided, Title I will not cover the cost of this medication. In addition, the Ryan White Letter of Medical Necessity is required at the time of initial referral explaining the contraindication, and MUST be submitted with a dated lab report showing the testosterone level results.**

IV. OTHER

	Generic Name	Trade Name (for reference only)
Antibiotics	Cephalexin	Keflex
	Penicillin (VK, benzathine, aqueous)	
	Amoxicillin / Clavulinic acid	Augmentin
	Ciprofloxacin	Cipro
	Lomefloxacin	Maxaquin
	Doxycycline	Vibra-Tab
	Tetracycline	
	Ofloxacin	Floxin
	Levofloxacin	Levaquin
Pain Medications	Naproxen	Naprosyn
	Ibuprofen	Advil, Motrin
	Acetaminophen	Tylenol
	Codeine	
	Morphine (oral, oramorph only)	
	Oxycodone	Roxycodone
	Morphine	MS Contin
	Aspirin EC	Aspirin EC
	Oxycodone / Acetaminophen 5/325mg (generic only)	Percocet 5/325mg
Cardiac / Hypertension Drugs	Verapamil	Calan
	Quinidine	Quinaglute
	Digoxin	Lanoxin
	Benazepril	Lotensin
	Furosemide	Lasix
	Hydrochlorthiazide	Hydrodiuril
	Atenolol	Tenormin
	Metoprolol	Lopressor
	Enalapril	Vasotec
	Captopril	Capoten
	Diltiazem CD	Cardizem CD
	Nifedipine XL	Adalat CC or Procardia XL
	Eprosartan (400mg & 600mg)•	Teveten
	Warfarin	Coumadin
	Nitroglycerin	Nitrotab/Nitro-stat SL tabs, Nitrolingual pump spray, Nitroglycerin caps, Nitro-Dur patches, Nitro-Bid ointment
Anti-emetics (vomiting)	Prochlorperazine♦	Compazine
	Metoclopramide	Reglan

Psychiatric Medications	Generic Name	Trade Name (for reference only)

	Valproate	Depakote
	Gabapentin	Neutrontin
	Atypical Antipsychotic	
	Olanzapine	Zyprexa
	Risperidone	Risperdal
	Quetiapine	Seroquel
	Anxiolytic	
	Lorazepam	Ativan
	Clonazepam	Klonopin
	Antidepressants	
	Mirtazarpine	Remeron
	Sertraline	Zoloft
	Lithium	Eskalith
	Paroxetine	Paxil
	Bupropion	Wellbutrin
	Citalopram	Celexa
	Venlafaxine	Effexor
Anti-ulcer	Antacids Multi-vitamins	Mylanta, Maalox
	Pantoprazole◊	Protonix
	Ranitidine (75mg)	Zantac (75mg)
Nutritional	Multi-vitamins	
	Anti-oxidants	
	Iron	Feosol
	Vitamin B-12 (Injection only)	Cyanocobalamin
	Potassium (Oral)	
	B-Complex Multivitamins	Berocca & Berocca Plus
	Lactase Enzyme (Oral)	Lactaid
	Lactobacillus Acidophilus (Granules)	Lactinex
Sleeping aids (Hypnotic)	Temazepam	Restoril
	Diphenhydramine	Benadryl
	Hydroxyzine (HCI & Pamoate)	Vistaril, Atarax
	Doxepin	Sinequan
	Trazondone	Desyrel
	Generic Name	**Trade Name (for reference only)**
Anti-histamines	Diphenhydramine	Benadryl Vistaril, Atarax

	Hydroxyzine (HCI & Pamoate)	
Cough Medications	Guaifenesin with codeine liquid	Robitussin
	Guaifenesin with dextromethorphan (without alcohol)	
	Guaifenesin with pseudoephedrine	
	Pseudoephedrine	Sudafed
Bronchodilators / Asthma	Albuterol	Proventil
	Beclomethoasone	QVAR (40mg&80mg)
	Fluticasone	Flonase
	Triamcinolone	Azmacort
	Theophylline Slow Release	Theodur, Theo-24
	Inhaler spacer (one time only)	Inhaler spacer
Ophthalmic / Otic Preparation	Sulfacetamide eye drops	Sulamyd
	Tobramycin eye drops	Tobrex
	Hydrocortisone/neomycin drops for ears	
	Gentamicin Ophthalmic (Solution & Ointment)	Garamycin
	Prednisolone-Acetate Ophthalmic	Pred Forte
	Homatropine Ophthalmic	Isopto Homatropine
	Brimonidine	Alphagan
	Acetazolamide	Diamox
	Timolol	Timoptic
	Dorzolamide	Trusopt
	Latanoprost	Xalatan
	Ofloxacin□	Ocuflox
Diabetic Medications	Glipizide ♦	Glucotrol
	Glyburide ♦	Micronase
	Metformin ♦	Glucophage
	Insulin*	Humulin, Novolin* (R, N, 70/30)
	Glyburide/Metformin	Glucovance
Cholesterol Reducing Drugs	Gemfibrozil ♦	LOPID
	Atorvastatin ♦	Lipitor
	Pravastatin ♦	Pravachol
	Niacin	Niaspan
	Generic Name	**Trade Name (for reference only)**

		Neupogen
Hematopoietic Agents	Filgrastim ♦ Erythropoietin ♦	Epogen, Procrit

NOTES:

- ∗ **Title I funds may only be used to reimburse for these medications for the treatment of insulin dependent diabetes mellitus secondary to HIV treatment, and must be written as such on the prescription.**

- In order to receive Eprosartan (Teveten) through the Ryan White Title I program, the patient must have had a prior history of intolerability to the use of Angiotensin Converting Enzyme (ACE) Inhibitors.

◊ The enclosed Ryan White Title I Letter of Medical Necessity for Pantoprazole (Protonix) must be signed by a Board certified gastroenterologist when this medication is indicated for the treatment of Erosive Esophagitis, or Barrett's Esophagus, or to treat a hypersecretory condition. In addition, the gastroenterologist must certify that a proton pump inhibitor is medically necessary.

◊ Indication of Pantoprazole (Protonix) for the treatment of Helicobacter pylori is restricted to a non-refillable ten (10) day supply of twenty (20) tablets to be prescribed no more than twice in a one-year period, in conjunction with the appropriate antibiotics. The prescription must state that this drug is "medically necessary for treatment of Helicobacter Pyroli."

 Ofloxacin (Ocuflox) is restricted to ophthalmologist use only for the indication of corneal ulceration.

V. MEDICATIONS AVAILABLE SPECIFICALLY FOR CHILDREN*

Famciclovir	Famvir
Cefaclor	Ceclor
Griseofulvin	Gris-peg
Phenobarbital	Phenobarbital

*** NOTE: Title I funds may only be used to reimburse for these medications for the treatment of indications experienced by HIV+ children 12 years and under. These medications are only available in liquid or suspension form.**

VI. DENTAL MEDICATIONS

Chlorhexidine Gluconate (0.12%)	Peridex